

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046314

FILED VS DEC 3 0 1960

6217

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6217

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Length of stay in 1b <b>25yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Menorah Medical Center</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2901 Harrison</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle Last <b>Rowe</b>				4. DATE OF DEATH Month <b>December</b> Day <b>10,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-14-94</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Willow Hill, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Elmer DeBow</b>			13b. MOTHER'S MAIDEN NAME <b>Nellie Lord</b>			14. NAME OF HUSBAND OR WIFE <b>Charles Rowe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Husband</b> Address <b>Home</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion of Myocard. Infarction 3da.</i> DUE TO (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. Month, Day, Year			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <b>Dec 7, 1960</b> to <b>Dec 10, 1960</b> and last saw her/him alive on <b>Dec 10, 1960</b> . Death occurred at <b>11:15</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>H. Passman</i> (Degree or title) <b>MD</b>				22b. ADDRESS <b>701 E 63</b>		22c. DATE SIGNED <b>12/10/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12-13-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
24. FUNERAL DIRECTOR <b>Mellody-cGilley-Eylar</b> ADDRESS <b>20 W. Linwood K.C.</b>			25. DATE RECD. BY LOCAL REG. <b>12-12-60</b>		26. REGISTRAR'S SIGNATURE <b>H-L-Dwyer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Passman

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed James E. Jackson

Licensed Embalmer No. 457

P. O. Address H. C. 9

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.